CHANGE IN STATUS AND/OR DISCONTINUANCE OF ADMINISTRATOR- IN-TRAINING PROGRAM

State Form 52639 (4-06)

Reset Form

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2051
E-mail: pla6@pla.IN.gov

Name of administrator-in-training	Name of preceptor
Name of facility	Telephone number of facility
Address of facility (*number and street, city, state, and ZIP code*)	

I do hereby notify the Board of the following change(s):

☐ Change of preceptor requested — Effective date (*month, day, year*): _____
New preceptor MUST complete a Preceptor Application form; you must receive notification of approval / denial of new preceptor prior to beginning program with another preceptor.

☐ Discontinuance of administrator-in-training program — Effective date (*month, day, year*): _____

☐ Other (please specify):_____

Identify which areas of training (i.e. orientation, nursing), if any, were completed by the administrator-in-training from the inception of the training to the date of discontinuance or change of status.

Reasons and / or comments:

AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the above statements are true, complete and correct.

Signature of preceptor	License number	Date (*month, day, year*)
Signature of administrator-in-training		Date (*month, day, year*)